IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 002790

FINDING INTO DEATH FOLLOWING INQUEST

Form 37 Rule 63(1)

*Section 67 of the **Coroners Act 2008***

Inquest into the Death of Mitchell Dean Johns

Findings of:	Coroner Ingrid Giles
Delivered on:	31 August 2026
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank, Victoria, 3006
Hearing dates:	24–28 February 2025 inclusive
Representation:	Mr Robert Harper of Counsel on behalf of Bendigo Health, instructed by Anabelle Weinberg of K&L Gates Ms Rachel Walsh of Counsel on behalf of Leanne Trickey, instructed by Kate Mellier of Lander & Rogers Mr Phillip Cadman of Counsel on behalf of Dr Natasha Tile, instructed by Tim Morrison of HWL Ebsworth
Counsel Assisting the Coroner:	Ms Fiona Batten of Counsel, instructed by Kajhal McIntyre, formerly of the Coroners Court of Victoria
Keywords:	Suicide attempt, insulin toxicity, medical management, mental health management, emergency department, *Mental Health Act 2014*, mental health and wellbeing principles

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INTRODUCTION

1. Mitchell Dean Johns[1] was 28 years old when he was found unresponsive at his home on 29 May 2021, following his discharge against medical advice from Bendigo Hospital the night before. At the time of his death, Mitchell lived alone with his cats in an apartment in Flora Hill (a residential suburb of Bendigo).

2. From the age of two, Mitchell was raised by his father, Mr Edward Johns (**Eddie**), along with his grandmother.

3. Mitchell was very intelligent and sociable growing up. He was articulate and was described as having a charisma about him that drew people to him. He completed a Certificate II in land management and several other TAFE certificates. Mitchell was also interested in gaming. He received an income from streaming his gaming activities, and he also edited videos and moderated a computer game called 'League of Legends'.

4. There are two matters in Mitchell's background that are of particular relevance to the circumstances of his death. The first matter is that in 2014, at age 21, Mitchell was diagnosed as a Type 1 diabetic.[2] He was prescribed insulin, both short and long-acting injections. In relation to the diagnosis, Eddie thought that Mitchell was faring well at the start, but then it "*hit him pretty hard*". Eddie recalled that Mitchell's words were "*taking insulin never cured anybody*". Mitchell only remained compliant with his insulin medication for approximately six months, before ceasing his medication completely.

5. The second relevant matter is that Mitchell had a history of mental ill health, self-harm and previous suicide attempts. He had a long history of depression with chronic suicidal ideation and had made previous suicide attempts in 2017.

6. Mitchell was also a member of the LGBTIQA+ community and had experienced a relationship breakdown prior to his death, and was described as "*pretty down in the dumps*".

[1] Referred to throughout this finding as 'Mitchell' unless more formality is required.
[2] Evidence supports that Mitchell was diagnosed as a Type 1 diabetic at this time, though his father Eddie gave evidence at inquest that he was at some point suspected of being a Type 2 diabetic, though the relevant tests to confirm this were never completed. *See* Transcript of inquest (**T**), Evidence at inquest of Eddie Johns, T-47 line 18 to T-48 line 23.

THE CORONIAL INVESTIGATION

Jurisdiction

7. Under section 4(2)(a) of the *Coroners Act 2008* (Vic) (**Coroners Act**), Mitchell's death was a 'reportable death', as his death occurred in Victoria and was considered '*unexpected, unnatural or violent or to have resulted, directly or indirectly, from an accident or injury*'.

Purpose of the coronial jurisdiction

8. The jurisdiction of the Coroners Court of Victoria (**the Court**) is inquisitorial.[3] The purpose of a coronial investigation is to independently investigate a reportable death to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which the death occurred.[4]

9. The cause of death refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

10. The circumstances in which the death occurred refers to the context or background and surrounding circumstances of the death. It is confined to those circumstances that are sufficiently proximate and causally relevant to the death.

11. The broader purpose of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through the observations made in the investigation findings and by the making of recommendations by coroners. This is generally referred to as the prevention role.

12. Coroners are empowered to advance their prevention role by:

    a) reporting to the Attorney-General on a death;

    b) commenting on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and

[3] Coroners Act, s 89(4).
[4] Coroners Act, Preamble, s 67.

c) making recommendations to any Minister, public statutory authority or entity on any matter connected with the death, including public health or safety or the administration of justice.[5]

13. Coroners are not empowered to determine civil or criminal liability arising from the investigation of a reportable death and are specifically prohibited from including a finding or comment or any statement that a person is, or may be, guilty of an offence.[6] It is not the role of the coroner to lay or apportion blame, but to establish the facts.[7]

Standard of proof

14. All coronial findings must be made based on proof of relevant facts on the balance of probabilities.[8] The strength of evidence necessary to prove relevant facts varies according to the nature of the circumstances in which they are sought to be proved.[9]

15. In determining these matters, I am guided by the principles enunciated in *Briginshaw v Briginshaw*.[10]

16. Proof of facts underpinning a finding that would, or may, have an extremely deleterious effect on a party's character, reputation or employment prospects demands a weight of evidence commensurate with the gravity of the facts sought to be proved.[11] Facts should not be considered to have been proven on the balance of probabilities by inexact proofs, indefinite testimony or indirect inferences. Rather, such proof should be the result of clear, cogent or strict proof in the context of a presumption of innocence.[12]

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[5] Coroners Act, ss 67(3), 72(1) and (2).
[6] Coroners Act, s 69(2).
[7] *Keown v Khan* (1999) 1 VR 69.
[8] *Re State Coroner; ex parte Minister for Health* (2009) 261 ALR 152.
[9] *Qantas Airways Limited v Gama* (2008) 167 FCR 537 at [139] per Branson J (noting that His Honour was referring to the correct approach to the standard of proof in a civil proceeding in the Federal Court with reference to s 140 of the *Evidence Act 1995* (Cth); *Neat Holdings Pty Ltd v Karajan Holdings Pty Ltd* (1992) 67 ALJR 170 at 170–171 per Mason CJ, Brennan, Deane and Gaudron JJ.
[10] (1938) 60 CLR 336.
[11] *Anderson v Blashki* [1993] 2 VR 89, following *Briginshaw v Briginshaw* (1938) 60 CLR 336.
[12] *Briginshaw v Briginshaw* (1938) 60 CLR 336 at pp 362–3 per Dixon J.

Investigation

17. My former colleague Coroner Katherine Lorenz (**Coroner Lorenz**) initially held carriage of the investigation into Mitchell's death. I assumed carriage of the investigation in July 2023 for the purposes of conducting additional investigations, conducting an inquest, and making findings.

18. Victoria Police assigned an officer, Leading Senior Constable Declan Douglas (**LSC Douglas**) of Bendigo Police Station to be the Coronial Investigator for the investigation of Mitchell's death. The Coronial Investigator conducted inquiries on behalf of the Court, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

19. Subsequently, the matter was also referred to the Coroners Prevention Unit (**CPU**)[13] for advice on the appropriateness of the care and treatment provided to Mitchell while he was in the care of Bendigo Health. On the CPU's advice, further materials were obtained, including an expert opinion from Professor Ann-Maree Kelly (**Professor Kelly**), Emergency Physician, and a statement from Associate Professor Sophia Adams, Chief Psychiatrist of Victoria (**Chief Psychiatrist**).

Request for inquest

20. On 13 September 2022, Eddie, Mitchell's father, filed a request for inquest into Mitchell's death (**Request**) seeking to examine a number of issues relating to the care and treatment provided to Mitchell at Bendigo Hospital in the lead-up to his death, including whether an assessment order ought to have been made at any point under the *Mental Health Act 2014* (Vic) (**Mental Health Act**), as then applied.

21. At a directions hearing convened on 29 July 2024, I indicated that I would grant the Request on the basis, amongst other things, that it would help clarify certain systemic issues

[13] The CPU was established in 2008 to strengthen the prevention role of the coroner. The CPU assists the coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. CPU staff include health professionals with training in a range of areas including medicine, nursing, and mental health; as well as staff who support coroners through research, data and policy analysis.

connected with the death, in a way that furthers the Court's public health and prevention objectives.[14]

Scope of inquest

22. A scope of inquest was subsequently finalised on 7 February 2025 as follows:

1. The adequacy of clinical care provided to Mitchell by Bendigo Health from 27 May 2021 until 28 May 2021, including:

a) Whether all appropriate steps were taken to manage Mitchell's presentation during his first admission on 27 May 2021 and his second admission on 28 May 2021, including to ensure an integrated approach to appropriately manage physical and mental health risks;

b) Whether all appropriate steps were taken by treating clinicians at the time that Mitchell indicated his intention to self-discharge against medical advice at approximately 4pm on 28 May 2021, including to:

i. assess whether Mitchell had capacity to refuse treatment;

ii. assess whether Mitchell met legislative criteria to be placed under an assessment order under the Mental Health Act 2014, as in force at the time;

iii. consider whether Mitchell should have been re-referred for a further assessment by the ED mental health clinician; and

iv. support discharge planning as appropriate in the circumstances;

c) Whether all appropriate steps were taken by treating clinicians at the time that Mitchell indicated his intention to self-discharge against medical advice at approximately 11.30pm on 28 May 2021, including to:

i. assess whether Mitchell had capacity to refuse treatment;

ii. assess whether Mitchell met legislative criteria to be placed under an assessment order under the Mental Health Act 2014, as in force at the time;

iii. consider whether Mitchell should have been re-referred for a further assessment by the ED mental health clinician; and

iv. support discharge planning as appropriate in the circumstances;

[14] Transcript of Directions Hearing, 29 July 2024, p. 2 line 28 to p. 3 line 11.

2. *Any opportunities for prevention, including with reference to the implementation status of recommendations emerging from the Bendigo Health Root Cause Analysis dated September 2021.*

In-court proceedings

23. The inquest was convened for four days of evidence from 24–27 February 2025 inclusive, with the Court reconvening on 28 February 2025 for oral closing submissions. Fiona Batten of Counsel was appointed as Counsel Assisting the Coroner, with three Interested Parties in total given leave to appear during the proceedings. Mitchell's father Eddie was present throughout the inquest.

24. A total of 11 witnesses gave evidence at the inquest, including:

    a) **Adjunct Associate Professor Hans de Boer**, Forensic Pathologist, Victorian Institute of Forensic Medicine (**VIFM**);
    b) **Mr Edward Johns**, Mitchell's father;
    c) **Dr Sanneil Mathias**, Emergency Physician Staff Specialist, Bendigo Health;
    d) **Ms Leanne Trickey**, Registered Mental Health Nurse, Bendigo Health;
    e) **Dr Debra Wood**, (then) Emergency Physician, Bendigo Health;
    f) **Dr Natasha Tile**, (then) Emergency Registrar, Bendigo Health;
    g) **Dr Ian Staples**, Emergency Department Consultant, Bendigo Health;
    h) **Associate Professor Philip Tune**, Clinical Director Mental Health and Wellbeing Service, Bendigo Health;
    i) **Dr Yvonne Higgott**, Emergency Physician and former Deputy Chief Medical Officer (Quality and Medico-Legal Portfolio);
    j) **Associate Professor Sophia Adams**, Chief Psychiatrist of Victoria; and
    k) **Professor Anne-Maree Kelly**, Emergency Physician, Court-appointed Expert.

Evidence

25. The present finding draws on the totality of the material obtained in the coronial investigation into Mitchell's death, namely: (a) the coronial brief prepared by LSC Douglas, which was supplemented by further material obtained by the Court; (b) the

transcript of the proceedings; (c) exhibits (which in this case, included: (i) the Coronial Brief Version 3 dated 13 January 2025; (ii) Additional Materials 1–10; and (iii) Medical Records);[15] as well as: (d) the closing submissions of Interested Parties.[16]

26. In writing this finding, I do not purport to summarise all the material evidence but refer to it only in such detail as appears warranted by its forensic significance and the interests of narrative clarity. It should not be inferred from the absence of reference to any aspect of the evidence that it has not been considered.

BACKGROUND

27. Mitchell had a past medical history of late onset Type-1 diabetes mellitus following significant weight gain when he was 21 years old. This in turn triggered depression, deliberate self-harm and suicide attempts. He had a history of admissions to Bendigo Hospital with diabetic ketoacidosis (**DKA**) due to non-compliance with both his insulin regime and diet, where he would discharge himself against medical advice as soon as he began to feel better, including on previous occasions in July 2016 and April 2017.

28. Medical records demonstrate that on 12 January 2021, approximately four months prior to his death, Mitchell again presented to the Bendigo Hospital Emergency Department (**ED**) with DKA. It was reported that he had previously self-ceased insulin and was non-adherent to any form of monitoring or treatment plan for his diabetes. He was treated pursuant to the DKA protocol and self-discharged before he was stabilised. His diagnoses of depression and anxiety were noted in medical records, but at the time, it does not appear that a referral for assessment of his mental health was considered or took place.

29. Mitchell declined any insulin upon discharge. Notably, a discussion was had between clinical staff and Mitchell and his father, who was present at the hospital. Medical records note "*D/w [discussion with] patient and father regarding welfare checks and family support - Dad will regularly be in contact and will have a key to access patient's house*

[15] Tendered on 28 February 2025 as Exhibits 1, 2 and 3 respectively. *See* T-480.
[16] These closing submissions are contained at T-479 to T-573.

(lives alone)".[17] Mitchell does not appear to have attended follow-up appointments after this time.

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Circumstances in which the death occurred

Circumstances of Mitchell's intentional insulin overdose

30. On 26 May 2021, Mitchell obtained scripts for insulin and then the insulin itself. On that day, Mitchell told Eddie that he needed to ring his doctor for an appointment. Eddie asked Mitchell what it was about, and Mitchell told him he wanted to obtain insulin.

31. At that point, Eddie's understanding was that Mitchell had not taken any insulin for over six years. Aware of this fact, Eddie enquired further about Mitchell's reasoning. Mitchell said that Eddie was "*always pestering him to get on it and … he wanted to do the right thing*".

32. Mitchell first attempted to get a prescription from Tristar Medical Centre in Kangaroo Flat but was informed that he needed to go through his previous treating General Practitioner (**GP**) at Tristar Medical Centre in Eaglehawk.

33. At 2.07pm, Mitchell had a telephone consultation with his previous GP, who issued a prescription via telehealth for:

    a) NovoRapid Flexpen, 100 units per millilitre, pen device 30 units, three times a day (short-acting insulin); and

    b) Optisulin, 100 units, 100 IU millilitres, cartridge 15, before bed (long-acting insulin).

34. The plan for review was described in medical notes as 'PRN' (as needed).[18]

35. Eddie then took Mitchell to Chemist Warehouse in Bendigo where he collected the insulin.

[17] Medical records, Tab 9, Discharge Summary for 12 January 2021 admission.
[18] Consultation notes of Dr Jafar Ahmed, recorded on 26 May 2021, Coronial Brief (**CB**) CB-22.

36. That afternoon, Mitchell told Eddie that he wanted to go to a bottle shop. Eddie thought this was strange because Mitchell did not usually drink alcohol, but assumed that Mitchell may have wanted drinks for his birthday in two days' time. At the bottle shop, Mitchell bought a bottle of Cointreau (an orange-flavoured French liqueur).

37. Eddie dropped Mitchell home to his apartment around dinner-time. When Eddie left, he observed that Mitchell "*seemed ok, there was nothing odd in his behaviour, he seemed in a decent mood, certainly nothing that gave [Eddie] any cause for concern*". Eddie told Mitchell he would call him the next day, but Mitchell told Eddie "*not to worry*" and to come and see him the day after instead, which was his birthday.

38. At 2.16pm the next day, 27 May 2021, Eddie tried ringing Mitchell with no response. Eddie made several further attempts to call Mitchell via Skype without answer, at which point he "*knew something wasn't right*".

39. Eddie drove to Mitchell's house and let himself in using a spare key. Upon entry, Eddie found Mitchell unconscious on the bedroom floor and noted that his breathing was shallow. Eddie called Triple Zero (**000**) and commenced cardiopulmonary resuscitation (**CPR**) until paramedics arrived.

Treatment by Ambulance Victoria paramedics

40. At 2.35pm, paramedics arrived and commenced a review. Mitchell "*initially appeared deceased as there was no active movement*" and he was not responsive to verbal or physical stimulus and had low blood sugar. He was also pale and had a Glasgow Coma Score (**GCS**) of 3, meaning that he was unconscious. Paramedics determined that Mitchell was likely unconscious because of his hypoglycaemic state.

41. The paramedics observed that Mitchell appeared underweight and quite frail, and also noted Mitchell's unit to be poorly kempt, with a significant amount of clutter and dirt on the floor, bugs crawling over furniture, several cats and a significant amount of animal faeces on the bathroom floor.

42. Mitchell received treatment[19] and began to return to a normal conscious state. Paramedics suggested that Mitchell should attend hospital, but he initially refused. The paramedics also observed that there were large amounts of insulin in the fridge and asked Mitchell if he had taken an intentional overdose of insulin. A doctor who was one of the first responders at the scene contacted Mitchell's GP and identified that Mitchell had more insulin than she felt was safe.[20] Paramedics observed that Mitchell had a flat mood, was speaking slowly and quietly, with poor eye contact and "*commenting that he did not care if he died due to hypoglycaemia*".

43. Eddie told paramedics that Mitchell had not been compliant with his medications and had been depressed. Because Mitchell had a history of mental illness, had suicidal ideation, poor self-care and there was a suggestion that hypoglycaemia was due to a suicide attempt, the paramedics requested police support to place Mitchell under section 351 of the *Mental Health Act 2014*[21] (**Mental Health Act**) for transport to hospital for further assessment.

44. Mitchell stated that he would not attend hospital unless the police forced him to attend. The police were called to assist, but ultimately Mitchell agreed with paramedics to be voluntarily taken to hospital. Paramedics administered him with olanzapine 5mg due to his irritability. Paramedics voiced concerns about the insulin remaining in Mitchell's home, however, it was understood that neither the paramedics nor the police had any legislative powers to remove the remaining insulin pens.

45. Paramedics resolved to inform staff at Bendigo Hospital about the quantity of remaining insulin at Mitchell's apartment, and proceeded to transport him to hospital. Paramedic Finlay recalls "*on arrival at Bendigo Hospital at 1604 hours, I handed the patient over to the nursing staff. During this handover I advised that there was a suspicion that the patient*

[19] The statement of Ambulance Victoria paramedic James Finlay states "*My treatment of this patient was to gain IV access with an 18 Gauge cannula in his right antecubital fossa, after which I administered 15 grams of glucose 10% at 1441, which I flushed before and after with 10ml of normal saline*". *See* CB-25.

[20] Evidence suggests that, at some point after being dropped off by Eddie the day prior, Mitchell selected two boxes of insulin, NovoRapid insulin aspart and Optisulin Solostar insulin glargine, which each contained five injection pens, and injected all ten pens into his body. A significant quantity of insulin remained in his residence.

[21] As then applied. The current legislation, which came into force on 1 September 2023, is the *Mental Health and Wellbeing Act 2022* (Vic), and the equivalent provision is s 232.

had taken an intentional overdose, and that there was still insulin at the patient's house which was potentially a risk, should the patient be discharged".[22]

First presentation to Bendigo Hospital[23]

46. On 27 May 2021 at about 4.09pm, Mitchell arrived at the Bendigo Hospital ED. Upon triage assessment, it was noted that he had been found on the floor of his flat by his father. He had looked unwell with a GCS of 3 (unconscious) which improved to 15 (normal) after administration of intravenous (**IV**) dextrose. Mental health issues were also identified. Mitchell was assigned Australasian Triage Scale Category 3 (target maximum time to see a doctor of 30 minutes).[24]

47. Mitchell was seen by a doctor at 7.41pm and disclosed that at approximately 2.00am that day (i.e. the early hours of the morning), he had taken an intentional insulin overdose. He stated that he took five tubes of each of Lantus (long-acting insulin) and NovoRapid (short-acting insulin). Each tube was maximally dialled. It was unclear how many units of insulin were in each syringe, and they were not with him. Mitchell reported having gone to sleep at approximately 6.00am and his father found him unresponsive at approximately 2.30pm. At that time, blood sugar level was unrecordable, and glucometer was showing a reading of '*lo*'.

48. Mitchell was diagnosed with hypoglycaemia due to an intentional insulin overdose. A treatment plan was formulated for ongoing management of his insulin-induced hypoglycaemia (with IV 10% dextrose infusion and food, and intermittent oral glucose gel and potassium as required), cardiac monitoring for a mild but persistent tachycardia, referral to the ED mental health clinician for psychiatric assessment (referred to as 'ECAT' in the medical records, which stands for 'Enhanced Crisis Assessment Team'), and admission to the ED Short Stay Unit (**SSU**) for ongoing observation and assessment.[25]

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[22] Statement of Ambulance Victoria paramedic James Finlay, CB-26.
[23] Mitchell's first presentation to Bendigo Hospital was from about 4.09pm Thursday 27 May 2021 to about 4.45pm Friday 28 May 2021. This presentation will be subject to further analysis and comment below.
[24] Medical records, Tab 7, ED Discharge Details for 27 May 2021.
[25] Professor Kelly describes the SSU in her report as "*an area attached to the ED where patients can undergo extended assessment and treatment for between 4-24h*". *See* CB-238.

49. At 6.29pm, Mitchell was assessed by the ED mental health clinician, Leanne Trickey (**Ms Trickey**), with her notes recorded at 7.28pm.[26] Ms Trickey described that Mitchell was brought in by ambulance due to a deliberate insulin overdose with intent to die and was referred for mental health review. He reported that he had a long history of depression and chronic suicidal ideation, with a previous attempt on his life in 2017. He reported non-compliance with his diabetic medication, stating he did not care about himself, and was dismissive regarding any concerns about his lack of care for his physical health.

50. Mitchell was unable to identify why he tried to kill himself that day, stating that he was depressed. He denied any precipitants for the suicide attempt that day. On exploration of his depressive symptoms, Mitchell reported experiencing anxiety and poor appetite, but was unable to articulate any other symptoms. Eddie noted that he was at a loss to provide a reason why Mitchell attempted suicide, stating that had appeared to be reasonably happy recently, however a brief same-sex relationship had ended about two weeks previously.

51. In the risk assessment, suicidality was rated as high and 'serious medical condition' was also coded as 'high' on the basis that he had "*poorly managed insulin-dependent DM*". It was noted that Mitchell was well-supported by his father and that his level of risk was highly changeable, though he denied ongoing suicidal intent. Mitchell also denied currently receiving any psychological or mental health treatment.

52. Ms Trickey noted Mitchell's self-report of depression, anxiety and suicidality but considered his presentation to be more consistent with emotionally unstable personality disorder (borderline type), with a differential diagnosis of ASD.[27]

53. The relevant entry of Ms Trickey noted the following management plan:

> "*For medical clearance re diabetes and OD. Discharge home with father. Accepting of referral to STTT with support of his father with the aim of*

[26] Ms Trickey's notes appear at Tab 14 of the medical records (CASP2 Psychiatric Assessment, pp. 22–37).
[27] Usually refers to autism spectrum disorder. Ms Trickey gave evidence at inquest that Mitchell's presentation was incongruent with his reported symptoms because in her experience*, inter alia*, "*someone who was… presenting with depression would be more distressed and upset and talking about what the issues are in their life*". *See* T-100 line 25 to T-101 line 10.

monitoring his suicidality given reported chronic SI and the high lethality of his attempt today and previous attempts. Requires further assessment of mental state and potential medical review re need for pharmacological treatment and diagnostic clarification."[28]

54. The plan following the mental health assessment was for Mitchell to be discharged home with his father once medically cleared, with STTT to follow up to monitor suicidality and undertake a further assessment of his mental state and the need for treatment. It was determined that Mitchell did not meet the criteria for an assessment order under the Mental Health Act at that time.[29]

55. During his treatment on 27 May 2021, Mitchell experienced recurrent low blood sugar levels between 10.26pm and 1.17am (several readings <3), and on 28 May 2021, he had two episodes of low blood sugar (2.2 at 6.09am and 2.8 at 11.12am) which were treated.

56. At 11.40am on 28 May 2021, Mitchell was transferred to the SSU for continuation of his IV dextrose therapy. At approximately 4.00pm, Mitchell indicated he would like to discharge himself against medical advice. Nursing staff and the SSU consultant, Dr Debra Wood (**Dr Wood**), attempted to discourage Mitchell from leaving, but he self-discharged at around 4.30pm. Dr Wood specifically told Mitchell that she thought he was at high risk of unconscious collapse and possible death from low blood sugar.

57. Prior to Mitchell leaving the hospital, the medical risks of discharge were explained to him, he had been referred for follow up with the Short-Term Treatment Team (**STTT**) as per the ECAT plan, and his father had been contacted in relation to Mitchell's intention to self-discharge. It was documented in the medical records that Mitchell "*meets neither the MHA nor duty of care to detain him involuntarily*". However, Dr Wood confirmed that at the time Mitchell self-discharged, he had unexpectedly exited via a different door following his conversation with his father, and that Dr Wood had anticipated a further conversation and assessment of Mitchell prior to him departing, in the course of which they would have

[28] The ShortTerm Treatment Team (**STTT**) is a mental health multi-disciplinary team that operates 7 days a week to provide access to community-based crisis assessment, support, and specialist treatment.
[29] Not documented in the ECAT notes but stated in the evidence of Ms Trickey at inquest. *See* T-104 lines 18–21.

continued to weigh the criteria under the Mental Health Act to determine whether such criteria were met.[30]

Second presentation to Bendigo Hospital[31]

58. At 5.51pm, just over an hour later, paramedics were dispatched to attend to Mitchell, who had been found unconscious by a bystander on the steps of the Chinese Museum while *en route* home from the hospital.[32] He was again attended to by ambulance and found to be hypoglycaemic, hypothermic, tachycardic and with a GCS of 4. His respiratory rate was slightly elevated at 24 breaths per minute, and blood pressure was normal at 127/88.

59. One of the paramedics who treated Mitchell, Ms Tanya Jeffery (**Ms Jeffery**), stated that "*my treatment of this patient was intravenous (IV) access with an 18G cannula to left back of forearm followed by IV Dextrose 10% approx. 150ml*".[33]

60. Mitchell was taken back to Bendigo Hospital ED, arriving there at 6.26pm. The assessment note of ED registrar Dr Natasha Tile (**Dr Tile**) was that, upon arrival to the ED, his blood glucose dropped low again, as did his GCS. He was given a further 25 mL of 50% dextrose, which resulted in his blood sugar level increasing to 4 and his conscious state returning to normal. His conscious state remained normal throughout the rest of his admission.[34]

61. The initial management plan was half hourly measurements of blood glucose, hourly venous blood gas analyses to check blood glucose and potassium levels, two doses of 25 mL of 50% dextrose (already given) followed by 10% dextrose infusion over 4 hours as well as food in the form of sandwiches and juice. Mitchell was referred to the General Medicine team for admission.

62. At some time between 9.30pm and 10.00pm, when Ms Trickey finished her shift, Dr Tile discussed Mitchell's case with Ms Trickey (the ECAT clinician who had assessed him the

[30] Evidence of Dr Wood at inquest. *See* T-174 line 14 to T-175 line 10.
[31] Mitchell's second admission was from around 6.26pm on Friday 28 May 2021 to approximately 11.30pm. This presentation will be subject to further comment below.
[32] This location is approximately 15-minute walk from the Bendigo Health ED.
[33] Statement of Ms Jeffery, Ambulance Victoria paramedic, CB-27.
[34] Medical records, Tab 1, p. 416; Expert opinion of Professor Kelly, CB-241.

previous day).[35] Ms Trickey advised Dr Tile that she had referred Mitchell to community mental health follow-up (with the STTT) which would follow him up on discharge. She called the STTT that evening because Mitchell had come into hospital and told them not to follow him up on that day, as he was in hospital. She advised that if he was still in hospital on the following Monday, he should have an assessment by the Consultation Liaison Psychiatry.

63. Mitchell was not seen or assessed by an ED mental health clinician during his second presentation to the ED.

64. At approximately 10.30pm, Mitchell again indicated that he wished to discharge himself against medical advice. Attempts were made by various staff members to dissuade Mitchell from leaving and included staff expressing concerns that there was a risk Mitchell could die, should he discharge against medical advice. At that time, Mitchell's heart rate was 111 beats per minute (elevated), blood pressure was 109/81, respiratory rate was 18 breaths per minute, oxygen saturation was 98% on room air, and temperature was 35.6°C. The most recent blood glucose had been 6.4 with ketones of 0.1. Physical examination was normal.

65. A General Medicine registrar medical record entry at 10.30pm noted that the verbal handover to them from nursing staff was that the ED mental health clinician had advised that Mitchell should stay in hospital but under a 'medical order' rather than a psychiatric order.[36] The medical registrar made two attempts to contact the ED mental health clinician which were reportedly unsuccessful. The registrar indicated that they were happy to admit Mitchell for medical treatment but would need psychiatric input regarding his admission against his will. It was noted that a psychiatric review would be needed.[37]

[35] The content of the conversation between Dr Tile and Ms Trickey will be the subject of further analysis below.
[36] These two concepts appear to distinguish between an assessment in relation to capacity under the *Medical Treatment Planning and Decisions Act 2016* (Vic) and a mental health assessment under the *Mental Health and Wellbeing Act 2014* (Vic).
[37] Medical records, Tab 1, p. 416.

66. At approximately 10.49pm, Mitchell refused to have IV therapy reconnected. It was negotiated that he would stay in the ED until 11.30pm pending formulation of a plan. The notes state that at this point, a 'Code Grey' was to be called should he try to leave.[38]

67. Dr Tile documented that, after assessment, Mitchell again indicated that he wanted to discharge himself against medical advice. It was documented that at the time, Mitchell was fully conscious (GCS 15) and was oriented to time, place and person. Dr Tile specifically documented that she relayed to him that "*he will have hypoglycaemia and die*" if he goes home. It was her impression that Mitchell understood the risks and repeated to her that he could die. Mitchell told her that he had sugar at home and could manage at home. He indicated that he would take a taxi home. Dr Tile warned that no one would find him at home because he lived alone, which he acknowledged.

68. Dr Tile discussed the patient with ED consultant, Dr Ian Staples (**Dr Staples**). An entry in the medical record noted:

> "*Discussed with ED consultant…who advised that patient has capacity and can self-discharge, cannot use duty of care to keep him*".[39]

69. Dr Staples stated that he did not personally review and assess Mitchell, but understood that he was fully conscious, was able to understand the risks associated with discharge and appropriately weigh these risks and treatment options and repeatedly communicated his decision to self-discharge home. Dr Staples also stated that he understood Mitchell had been assessed by the ECAT and that the ECAT clinician did not consider that he met the criteria for compulsory assessment or treatment.

70. Three attempts were made to contact Mitchell's father but were unsuccessful.[40] There was no documented reference to consideration of an assessment order by medical staff.

71. Mitchell self-discharged against medical advice at approximately 11.30pm.

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[38] Medical records, Tab 1, p. 289. A Code Grey would have resulted in the calling of security and other personnel.
[39] Medical records, Tab 2, p. 225.
[40] It is noted in this connection that these attempts would have been late in the evening (10.30pm onwards).

Events following Mitchell's second self-discharge

72. At 11.52pm, Mitchell sent a message to Eddie that said, "*All the cats were already inside when I got home, so Eddie you didn't count right or the only ones outside were the usual ones and the others were hiding*".

73. The next morning, on 29 May 2021, Eddie woke at 7.00am and saw the message from Mitchell. Eddie sent a message back to him at 7.09am, but Mitchell did not respond. Eddie sent another message to Mitchell at 9.30am and did not get a response. Eddie decided to check on Mitchell.

74. At 10.15am, he went to Mitchell's home and found Mitchell lying on his back in his bed unresponsive and not breathing. Eddie called '000' and commenced CPR. The paramedics arrived and took over the CPR, but sadly at 10.33am, Mitchell was declared deceased.

75. At approximately 10.50am, the police arrived at Mitchell's home. They observed that there were 13 boxes of insulin in the fridge. That is, the 15 boxes of insulin Mitchell obtained on 26 May 2021 were all accounted for. It appeared that Mitchell had not ingested any further insulin following the initial ingestion on 27 May 2021.

76. Police conducted an investigation and determined that there were no suspicious circumstances.

Identity of the deceased

77. On 29 May 2021, Mitchell Dean Johns was visually identified by his father, Edward Johns. Identity is not in dispute and requires no further investigation.

Medical cause of death

78. Forensic Pathologist Dr Hans de Boer of the VIFM, who has since been elevated to Adjunct Associate Professor Hans de Boer (**Adj. A/Prof de Boer**), performed an autopsy on Mitchell's body on 14 June 2021. Adj. A/Prof de Boer also considered various materials including the Victoria Police Report of Death for the Coroner (**Form 83**), the post-mortem computed tomography (**CT**) scan, and medical notes from Bendigo Hospital, and provided

a written report of his findings dated 22 July 2021.[41]

79. Adj. A/Prof de Boer noted in his report that the biochemistry testing that was performed as part of the post-mortem examination confirmed the presence a large quantity of insulin (>300 mU/L, normal value <15.0 mU/L). Such high quantities of insulin cause rapid uptake of glucose from the blood stream, inducing a low blood sugar (hypoglycaemia), which can progress into coma and death. The unmeasurably low level of C-peptide (<0.03 nmol/L) confirms that the insulin was exogenous in nature (i.e. that it had been administered from an external source, rather than being produced by the body).[42]

80. Post-mortem glucose levels were unmeasurably low (<0.3 mmol/L). This is consistent with a hypoglycaemic death but is also of limited diagnostic value since blood glucose levels diminish after death due to glycolysis.

81. Adj. A/Prof de Boer provided an opinion in his report, maintained at inquest, that the medical cause of death was *1(a) Hypoglycaemia due to administration of exogenous insulin*.

82. Adj. A/Prof de Boer stated at inquest that arriving at the cause of death was essentially a "*process of exclusion*" insofar as hypoglycaemia cannot be diagnosed post-mortem, given that every person who dies has a very low blood sugar. Therefore, a full autopsy was conducted to look for alternative causes of death, which were not found. Adj. A/Prof de Boer formulated Mitchell's cause of death, based on "*the highly suggestive circumstances, and the laboratory testing providing that he took exogenous insulin*".[43]

83. In closing submissions, Counsel Assisting urged me to accept the opinion of Adj. A/Prof de Boer, submitting that, in addition to the cogency of the evidence flowing from the post-mortem examination, the formulation of the cause of death is consistent with the known

[41] *See* Medical Examiner's Report of Dr Hans de Boer, 22 July 2021, CB-67 to CB-78.
[42] *See* Evidence at inquest of Adj. A/Prof de Boer, T-13 line 27 to T-14 line 7: "*Insulin is a hormone produced by the body itself to regulate the level of glucose. Now when the body produces insulin it also produces C-peptides. So whilst insulin is being produced it also produces C-peptides. So that means that if insulin comes from the body itself, it's made by the body itself, you have both insulin and C-peptide in the body. In this case there's a high level of insulin with a very low level of C-peptides which essentially proves that the insulin is not made by the body itself but it's coming from outside the body, in this case as a medication*".
[43] *See* Evidence at inquest of Adj. A/Prof de Boer, T-19 lines 28–29 and T-20 lines 3–15.

evidence about Mitchell sourcing and ingesting insulin immediately prior to death.[44]

84. Counsel Assisting noted in closing submissions that the evidence from Eddie was that, on 26 May 2021, Mitchell obtained a prescription over the phone from his old treating doctor, and collected rapid-acting and long-acting injecting pens from the pharmacy.[45]

85. Further, it is known from what Mitchell later told hospital staff, the GP prescription of 26 May 2021, and the photographs taken by police of the remaining insulin in Mitchell's refrigerator[46] that at around 2.00am on 27 May 2021, Mitchell attempted suicide by intentionally administering:

    a) 5 pens of NovoRapid (rapid-acting) insulin aspart – 1,500 Units; and

    b) 5 pens of Optisulin (long-acting) insulin glargine – 1,500 Units.

86. Each pen contained 3 mL of insulin and had 100 Units of insulin per mL.[47] Mitchell told hospital staff each tube was maximally dialled.[48] He therefore administered 1,500 Units of insulin aspart and 1,500 units of insulin glargine.

87. While carefully guarding the boundaries of his expertise, Adj. A/Prof de Boer's evidence was that long-acting insulin was designed to last for about a day, but that it is known from publications and case series that if one overdoses on long-acting insulin, one can have hypoglycaemic complications (very low blood sugars) for multiple days after the overdose.[49] Adj. A/Prof de Boer agreed with a suggestion from Counsel Assisting that if there was no evidence of Mitchell taking any further insulin after 27 May 2021, it was possible the post-mortem levels identified by way of biochemistry testing were reflective—exclusively—of the effects of the insulin Mitchell self-administered at 2.00am on 27 May 2021.[50]

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[44] *See* Submissions of Counsel Assisting, T-481 line 16 to T-483 line 5.
[45] Statement of Edward Johns, CB-12.
[46] Medical records, Tab 2, p. 228; Additional Materials (**AM**) AM4-2 and AM4-4.
[47] AM4-2.
[48] Medical records, Tab 2, p. 228.
[49] T-18 line 24 to T-19 line 1.
[50] T-19 lines 16–27. I also consider this to be consistent with the evidence of Professor Kelly who opined that for this sort of overdose, medical treatment for a week may be required in order to have full recovery. *See*T-380 lines 21–25.

88. Having considered both Adj. A/Prof de Boer's detailed and comprehensive report, and his evidence at inquest, which I considered to be illuminating indeed, and noting that there was no evidence of any other cause of death for Mitchell following the autopsy procedure (given the absence on toxicological analysis of any alcohol or drugs, and the lack of evidence of post-mortem injuries or of natural disease),[51] I accept Adj. A/Prof de Boer's opinion and formally determine the cause of Mitchell's death to be *Hypoglycaemia due to administration of exogenous insulin*.

ANALYSIS OF CARE PROVIDED TO MITCHELL BY BENDIGO HEALTH

89. The investigation into Mitchell's death revealed critical points at which Mitchell could have been provided with better and more person-centred, integrated care while he was a patient of Bendigo Health, as well as highlighting certain frailties in the systems supporting integrated patient care at the hospital. These issues bring into sharp relief the potential preventability of Mitchell's death, which I will address below.

90. Some of these issues were identified through the Root Cause Analysis (**RCA**)[52] conducted in 2021 following Mitchell's death, with additional systems improvements and gaps in care identified through *viva voce* evidence heard at inquest, including via the expert evidence of Emergency Physician Professor Anne-Maree Kelly (**Professor Kelly**) and Victoria's Chief Psychiatrist, Associate Professor Sophia Adams (**A/Prof Adams**).

First presentation to Bendigo Hospital

Initial triage, clinical assessment and initial management

91. Professor Kelly opines that, upon his first presentation to Bendigo Hospital on 27 May 2021, Mitchell's triage, clinical assessment and initial management were reasonable and appropriate, given that appropriate information was collected, an appropriate priority assigned, an accurate working diagnosis was made, and appropriate initial treatment was

[51] *See* Medical Examiner's Report of Dr Hans de Boer, 22 July 2021, CB-69, comment 5.
[52] The outcome of the RCA is summarised in the statement of Dr Beverley Ferres (Dr **Ferres**), dated 19 April 2023, CB-43–49. Mitchell died prior to the amendments to the *Health Services Act 1988* (Vic) requiring health services to conduct a formal Serious Adverse Patient Safety Event (**SAPSE**) review in certain circumstances. However, Bendigo Health confirmed that Mitchell's death was reported to Safer Care Victoria (**SCV**) as a Sentinel Event and the RCA was conducted per the SCV Sentinel Event Program, and as such, fulfilled the requirements of sentinel event reviews in place at the time.

implemented.[53] I accept Professor Kelly's opinion in this regard.

Management of the overdose and placement of Mitchell in the Short Stay Unit

92. While considering the overall plan was appropriate, Professor Kelly raised the question of whether clinicians were aware of the severity of Mitchell's insulin overdose and for how long he might have required treatment in order to stabilise his blood sugars,[54] questioning the decision to transfer him to the SSU (which by its very name denotes that patients will usually only be required to stay for a short period), along with the decision not to seek input from the Victorian Poisons Information Centre (**VPIC**) to assist in managing the overdose.

93. The evidence of Dr Sanniel Mathias (**Dr Mathias**), the supervising consultant in the ED of the evening of 27 May 2021, was that he felt comfortable managing a single agent overdose of this nature without seeking input from the VPIC, and considered that the decision to transfer Mitchell to the SSU was a reasonable decision in circumstances where, noting *inter alia* that if Mitchell required a longer period of treatment, he would simply be transferred to the medical team for ongoing care after 48 hours if that was necessary.[55]

94. I accept this. Given that there is no evidence that either decision contributed to the ultimate outcome for Mitchell, I do not propose to traverse these decisions in any great detail. However, in light of Professor Kelly's expert opinion, and without making adverse comment in relation to either decision, I consider that Mitchell's case demonstrates that even a single agent overdose can give rise to highly complex management considerations, particularly in the context of a combination of rapid-acting and long-acting insulin injections, that may require more than 24 hours of treatment and observation. Having clarity and expert input on the likely duration of symptoms and/or an optimal management plan (such as through consulting the VPIC), even for the most proficient and confident

[53] Expert opinion of Professor Kelly, CB-261. I note that it does not appear that Mitchell was seen by a doctor within the half-hour target timeframe but there is no evidence this had any bearing on the care that was provided, nor the ultimate outcome.
[54] *See* evidence of Professor Kelly, T-380 lines 21–27: "*This as an episode of care where there has been an acute suicide attempt but the effects of that are long term, that - they could be a week, there are many pages published that this would be – required treatment for a week in order to have full recovery. I think that was under appreciated by the emergency clinicians and certainly by the mental health clinicians*".
[55] Evidence at inquest of Dr Mathias, T-71 lines 9–17.

clinician, ensures that early decisions set the patient up for optimal management by all who may subsequently treat them.

95. Notably, Dr Debra Wood (**Dr Wood**), the SSU Consultant rostered on for the afternoon of 28 May 2021, gave evidence that they believed Mitchell "*wouldn't have been transferred to the short stay unit if there was thought to be that he was going to have recurrent hypoglycaemias. There's an implication that somebody is fairly stable by the time they go up there*".[56] This underscores the importance of the initial management plan of an insulin overdose and the treatment pathway that follows.[57]

Mental health assessment and planning

96. The ECAT clinician who assessed Mitchell in the ED on 27 May 2021, Ms Trickey, is a registered mental health nurse and had 26 years' experience at the time of Mitchell's episode of care. However, her only experience in working in the ED was when she was rostered on to work at the Bendigo Hospital ED for two months at around the time that coincided with Mitchell's presentation.

97. Notwithstanding her lack of experience in the ED environment, Counsel for Ms Trickey submitted, and I accept, that Ms Trickey was a deeply experienced clinician who conducted a thorough assessment of Mitchell, including seeking collateral information from his father Eddie (including in Mitchell's absence). Her assessment of Mitchell is noted in some detail in the records.

98. I consider that Ms Trickey's assessment of Mitchell's risk, and the immediate management plan—for Mitchell to be discharged home with his father once medically cleared, with STTT to follow up to monitor suicidality and undertake a further assessment of his mental state and the need for treatment—was appropriate based on the information known to her at the time. At the point when Mitchell was accepting of treatment, he did not meet the

[56] Evidence at inquest of Dr Wood, T-149 lines 10–15.
[57] Dr Wood gave evidence at inquest that, in the case of an insulin overdose, they would consult with the VPIC "*at the outset perhaps, to try and anticipate how long, you know, we were going to require treatment for, and I would - if I was one of the beginning physicians that might determine where I thought how long, for example, this person was going to require treatment for, and at other key points*" – T-141 lines 25–30.

criteria for an Assessment Order, as Ms Trickey appropriately concluded.[58] Ms Trickey appropriately identified that Mitchell would require further diagnostic clarification regarding her impression of borderline personality disorder (**BPD**), along with further risk assessment.

99. However, a strong theme in the RCA, as well as the expert opinions of Professor Kelly and A/Prof Adams, was the need for better information-sharing and integration of medical and mental health treatment and planning for Mitchell, in light of the fact that neither ECAT nor clinicians in the ED and SSU had available to them all information which would have best supported their decision making. This is properly categorised as a systems issue rather than any deficiency on the part of the approach of individual clinicians.

100. Indeed, the evidence of Ms Trickey was that she was not apprised of the following information which would or which would possibly have been relevant to the risk assessment, and in some cases to the treatment plan, namely:

    a) Mitchell had voiced to paramedics from Ambulance Victoria (**AV**) on 27 May 2021 that he did not care if he lived or died;[59]

    b) AV paramedics had voiced concerns to hospital staff that Mitchell was a "*flight risk*";[60]

    c) Mitchell had a significant history of self-discharging against medical advice;[61]

    d) Mitchell had disclosed at triage the amount of insulin consumed, being five vials of NovoRapid and five full vials of Optisulin, stating that he has depression and was wanting to die, that he had made previous attempts on his life, does not see

[58] Ms Trickey did not record this in her notes but confirmed at inquest that Mitchell was assessed under the Mental Health Act and found not to meet the criteria for involuntary treatment. *See* T-104 lines 18–21. Best practice would of course have been to explicitly include this assessment in the medical records, though no adverse comment flows.
[59] Evidence at inquest of Ms Trickey, T-96 lines 17–24.
[60] This reference is contained in the partially visible triage notes at Tab 8 of the medical records and was put to Ms Trickey at T-98 lines 26–31. I note that paramedics had also indicated they voiced concerns about the large quantities of leftover insulin that remained in Mitchell's residence, however this aspect was not further explored at inquest noting that the evidence suggested Mitchell had not used any further insulin prior to death.
[61] Evidence at inquest of Ms Trickey, T-97 lines 25–27.

anyone for his mental health and "*got quite teary talking about his intentions*";[62] and

e) Mitchell was at very high risk of serious harm including death unless he received treatment[63] and that death remained possible if the treatment was not completed.[64]

101. Similarly, the ED and SSU clinicians were not aware of certain information which might have assisted them in making decisions regarding Mitchell's care.

102. While all Mitchell's clinicians agreed that mental health risk assessment is dynamic rather than static, such that a patient should be re-assessed if there is any significant change in risk profile (which includes refusal of life-saving medical treatment),[65] the ED and SSU clinicians did not have visibility of which specific factors had or had not been considered by Ms Trickey in forming her risk assessment and the immediate management plan. For example, the ED clinicians were not aware that Ms Trickey's assessment had not considered the potential consequences of self-discharge and was premised on Mitchell completing treatment for his overdose.[66]

103. Dr Wood gave evidence that it would have been helpful to know if the ECAT team had considered the contingency in its assessment as to what might happen if Mitchell changed his mind and no longer agreed to stay in hospital, as opposed to being discharged once he was assessed as medically stable.[67]

104. Ms Trickey gave evidence at inquest that she understood that Mitchell's subsequent refusal of treatment changed his risk profile such that fresh consideration needed to be given to whether Mitchell met the criteria for an assessment order.[68] Further, Ms Trickey considered

[62] Evidence at inquest of Ms Trickey, T-97 lines 11–18. Mitchell's presentation at this point appears to have contrasted to that during his interview with Ms Trickey, when she expressed that he had no affect congruent with depression and did not appear upset.
[63] Evidence at inquest of Ms Trickey, T-98 lines 4–6.
[64] Evidence at inquest of Ms Trickey, T-102 lines 26–28. Ms Trickey stated that had she known that Mitchell was at very high risk of serious harm including death, she would have sought further consultation with a colleague or discussed it with the on call psychiatrist. *See* T-107 lines 17–21.
[65] Evidence at inquest of Dr Mathias, T-65 lines 17–22; Ms Trickey T-113 lines 18–21; Dr Wood T-151 lines 7–11; Dr Staples T-222 lines 2–26.
[66] Evidence at inquest of Ms Trickey, T-102 lines 20–21; T-106 lines 17–19.
[67] Evidence at inquest of Dr Wood, T-145 lines 13–17.
[68] Evidence at inquest of Ms Trickey, T-118 lines 19–20; T-121 lines 9–12; T-118 lines 21–23.

that a shift in the discharge plan, whereby the protective factor of being discharged into Eddie's care was no longer part of the discharge plan (whereby Mitchell sought to discharge himself early without his father), would result in increased risk such that Mitchell may have met the criteria for an assessment order insofar as that protective factor was part of the least restrictive treatment that was available.[69]

105. Moreover, there were differing understandings in regard to the terminology of 'cleared by ECAT'. Ms Trickey's evidence was that 'cleared by ECAT' meant only that Mitchell had been seen by ECAT and that no order had been under the Mental Health Act.[70] However, Dr Wood understood the notation 'cleared by ECAT' to mean that the ED mental health service had reviewed Mitchell and assessed that he was suitable for discharge once his medical issues had been adequately addressed.[71]

106. It is salient to note here that Ms Trickey had assessed Mitchell as having a highly changeable level of risk, being "*unpredictable due [to] inability to identify [precipitating] factors to suicide attempts*".[72] It is not clear that this changeability was appreciated by ED and SSU clinicians or factored into subsequent decision-making, despite that it was identified within hours of Mitchell presenting to hospital, with clinicians instead believing that the initial ECAT assessment and plan remained current.

Should an assessment order have been made on the afternoon of 28 May 2021?

107. When Mitchell indicated he wished to go for a cigarette on the afternoon of 28 May 2021, which Dr Wood later suspected was a "*ruse*" for wishing to self-discharge, Dr Wood formed an opinion that they did not have sufficient grounds to be satisfied that Mitchell appeared to have a mental illness.[73] Specifically, Dr Wood did not consider that Mitchell's previous suicide attempt was sufficient evidence to form an appearance of mental illness in and of itself, absent some other evidence of mental illness such as active psychosis. Further, Dr Wood did not consider that there were sufficient indicators to conclude that

[69] Evidence at inquest of Ms Trickey, T-119 lines 5–9.
[70] Evidence at inquest of Ms Trickey, T-112 lines 25–26.
[71] Evidence at inquest of Dr Wood, T-143 lines 25–31.
[72] Medical records, Tab 1, p. 479.
[73] Evidence at inquest of Dr Wood, T-152 lines 1–14.

Mitchell was "*depressed such that he had a mental illness*" or that his refusal of treatment was or could have been due to mental illness.[74]

108. Dr Wood confirmed at inquest that they had in fact themself explicitly commenced an assessment of Mitchell under the Mental Health Act (while simultaneously assessing his capacity) at the point he indicated he wished to discharge, and did not form the opinion that he met the criteria of having a mental illness. Noting that this is reflected in the contemporaneous medical records, I accept the evidence of Dr Wood that they assessed Mitchell under the Mental Health Act on the afternoon of 28 May 2021 and considered at that point that he did not meet the criteria for an assessment order.

109. Dr Wood acknowledged, however, that they did not have all relevant information in relation to Mitchell's risk factors in order to assess whether he met the relevant criteria, and noted that they may have benefited from having had easier access to the full ECAT assessment[75] which they understood was only available by going downstairs to the ECAT offices to view the notes on their computer.[76] Dr Wood also noted that they were not aware of the details of the immediate management plan, including that Mitchell was to be discharged into the care of his father,[77] who was noted in Ms Trickey's assessment as a "*significant protective/resilience factor*".

110. Dr Wood considered that ideally, a more comprehensive psychiatric assessment would have been undertaken at the point of Mitchell's self-discharge, however this was not practicable in the circumstances, given that Mitchell was no longer agreeing to treatment and this may have required them to call a Code Grey which may have resulted in the use of physical restraint or chemical restraint in order to prevent Mitchell from leaving.[78] Dr Wood stated that they did not consider specifically that an assessment order could be appropriate to allow more time for a full assessment.[79]

[74] Evidence at inquest of Dr Wood, T-153 lines 7–13.
[75] Evidence at inquest of Dr Wood, T-155 lines 3–6.
[76] Evidence at inquest of Dr Wood, T-157 lines 2–9.
[77] Evidence at inquest of Dr Wood, T-164 lines 21–26.
[78] Evidence at inquest of Dr Wood, T-160 lines 7–27.
[79] Evidence at inquest of Dr Wood, T-161 lines 21–25.

111. The evidence of the Chief Psychiatrist A/Prof Adams was she would make an assessment order in those circumstances but that different clinicians would have different views, that it is a "*very grey space*", and that could also be considered reasonable or justifiable that an assessment order was not made.[80] Professor Kelly's opinion was that it would be reasonable to make an assessment order, but that there would be "*variation in practice and variation in opinion*" and she could understand why people may think it would be reasonable not to make an assessment order.[81]

112. In the circumstances, I consider that there is no basis to make an adverse finding against Dr Wood for electing not to make an assessment order in relation to Mitchell on the afternoon of 28 May 2021. The salient point in my view is that Dr Wood did not have access to the full suite of information that would have placed them in the best possible position to make that decision as to whether this was warranted in what were very complex circumstances. This was due to a lack of appropriate systems at Bendigo Health promoting integration of the medical and mental health plans for Mitchell, which I will address further below.

113. I note also for completeness that Dr Wood was a thoughtful and considered witness with a previous background as a psychiatrist, a role they have since returned to, and was deeply experienced in conducting mental state assessments. The evidence supports that Dr Wood's assessment of Mitchell's capacity was appropriate, and while their assessment of his mental state was not able to be comprehensive in the conditions, they spent some time with Mitchell to understand what was motivating his desire to discharge. Their approach was relational, caring and reflective.[82] Dr Wood did state that, with the benefit of hindsight, namely knowledge of the tragic outcome, they might have approached the question of whether Mitchell met the criteria under the Mental Health Act differently.[83]

[80] Evidence at inquest of A/Prof Adams, T-464 line 29 to T-465 line 9.
[81] Evidence at inquest of Professor Kelly, T-465 lines 17–23.
[82] I note they later approached Mitchell's treating team in the ED to suggest a further ECAT referral when he later re-presented that evening. *See*T-166 lines 9–14. For completeness, while Eddie expressed concerns about the inability of SSU staff to escort Mitchell off the premises for a cigarette, I accept that this was not feasible for staff to facilitate.
[83] Evidence at inquest of Dr Wood, T-177 line 22 to T-178 line 4.

Post-discharge steps

114. With respect to action that ought to have been taken post-discharge, Dr Wood agreed with the opinion of Professor Kelly that Mitchell's father Eddie ought to have been contacted after Mitchell self-discharged, to encourage him to return to the ED and to emphasise the importance of someone being there with Mitchell to monitor his condition and call for help if needed. I consider that, even where the SSU clinicians might have been unaware that Mitchell's father was a key part of the plan devised by Ms Trickey, this ought to have been a matter that the SSU clinicians turned their mind to independently of the ECAT assessment, given that Mitchell was discharging himself to home alone after a high-lethality suicide attempt with an ongoing risk of recurrent hypoglycaemia.

115. However, given that Mitchell re-represented to hospital less than two hours later, and had himself contacted Eddie, there is no evidence it impacted the outcome on this occasion.

Second presentation to Bendigo Hospital

Initial triage, clinical assessment and initial management

116. Professor Kelly opines that, upon his second presentation to Bendigo Hospital on 28 May 2021 at around 6.00pm, Mitchell's triage, clinical assessment, initial management and disposition planning were reasonable and appropriate, given that appropriate information was collected, an appropriate priority assigned, an accurate working diagnosis was made, and appropriate initial treatment was implemented.[84] I accept Professor Kelly's opinion in this regard.

Should there have been a re-assessment of Mitchell's mental state upon his re-presentation?

117. In this instance, the evidence is unclear as to whether or not a request was made by ED clinicians to ECAT for Mitchell's mental state to be re-assessed during his re-presentation to Bendigo Hospital. The evidence supports that a conversation occurred between Ms Trickey and Dr Tile between 9.30pm and 10.00pm, and that Dr Tile was very concerned for Mitchell's mental state, but the evidence is conflicting as to the contents of that

[84] Expert opinion of Professor Kelly, CB-264–5.

conversation, including whether a re-referral was made to ECAT or where what transpired was simply a "*corridor conversation*".[85]

118. I do not consider that it is necessary to resolve this issue, but only to note that following the conversation, no fresh mental state assessment of Mitchell was conducted by ECAT or any ED or other clinician during Mitchell's second presentation to hospital. In particular, the evidence is that no formal assessment was made as to whether Mitchell met the criteria for an assessment order under the Mental Health Act. Bendigo Health has conceded that a face-to-face mental state examination did not occur, and should have occurred.[86]

119. While maintaining that there was no re-referral to ECAT, Ms Trickey agreed at inquest that it would have been appropriate for Mitchell's mental state to be re-assessed upon his admission on the evening of 28 May 2021. This was taking into account that Mitchell had been non-compliant with treatment, acted contrary to the agreed management plan by leaving hospital alone, and that there was a very high risk of serious harm including death.[87] Ms Trickey also noted in hindsight that had she been made aware that Mitchell was intending again to self-discharge against medical advice, in circumstances where there was a risk of death, she would have consulted with the psychiatrist on call to consider whether he met the criteria for an assessment order given his refusal of physical health treatment.[88] Ms Trickey was able to herself place patients on an assessment order but noted that the practice was to first call the consultant psychiatrist prior to taking such action.

120. Professor Kelly opined that reasonable practice would have entailed Mitchell being re-assessed by the ED mental health clinician. This was because "*Mitchell's risk profile and*

[85] There are differing accounts as to whether Mitchell was 're-referred' for assessment by the ED mental health clinician on 28 May 2021, including regarding the discussion that ensued between Dr Tile and Ms Trickey. Dr Tile describes that she discussed Mitchell's case with the ED mental health clinician at about 9.30pm, including the risk of him self-discharging, and was advised that the ED mental health clinician's assessment of Mitchell would be unchanged from that of the previous day and that Mitchell was not on an Assessment Order under the Mental Health Act. It is unclear whether Dr Tile specifically discussed Mitchell's risk of death if he self-discharged again. Dr Tile explained that she did not re-refer Mitchell again when he was indicating a desire to discharge at about 10.30pm, as she had already spoken with the ECAT about the possibility of him self-discharging. Ms Trickey describes a more general discussion with Dr Tile about Mitchell's non-compliance with treatment for his diabetes rather than a specific discussion about the changed risk caused by his self-discharge and likelihood of self-discharging again. In her view, the discussion with Dr Tile was a "*corridor conversation*" and did not appear to be a re-referral to the ECAT.
[86] Submissions of Counsel for Bendigo Health, T-515 lines 15–17.
[87] Evidence at inquest of Ms Trickey, T-123 lines 16–21.
[88] Evidence at inquest of Ms Trickey, T-130 lines 8–17.

circumstances had changed. He had suffered a further life-threatening episode of hypoglycaemia after self-discharge and was at risk of wanting to self-discharge again (based on his previous behaviour)".[89]

121. This is also consistent with the opinion of the Chief Psychiatrist who opined that even for someone who had previously been assessed as not meeting the criteria for an assessment order, a subsequent refusal of medical treatment where refusal may result in death would raise the need to reconsider whether the legislative criteria applies. This is because "*all risk and capacity decisions are dynamic and both decision and situation dependent. Refusal of medical treatment is another piece of information that would be integrated into the risk assessment process. Each refusal of medical treatment that could lead to death should be assessed individually and may be considered to have potential to increase risk*".[90]

122. Professor Kelly also emphasised at inquest that, in addition to the staff in specialist mental health teams, senior ED doctors ought also to be empowered to independently consider application of the Mental Health Act in circumstances where they consider the criteria are met and the risk of serious harm or death is clear and imminent. This is permitted by the legislation but, in Professor Kelly's experience, when an ED mental health clinician is available, local practice is often to defer to them to make this judgement. Dr Staples gave evidence at inquest that, with the benefit of hindsight, and while he had confidence in Dr Tile's assessment of Mitchell, he may have assessed Mitchell himself in person and would now have greater confidence in his own ability to use the Mental Health Act where required.

<u>*Should an assessment order have been made?*</u>

123. Professor Kelly's evidence was that, where a patient has made a suicide attempt and is subsequently refusing treatment in the face of risk to life or risk of serious irreversible harm, the only tool in her armamentarium she would have to hold the patient, would be an

[89] Expert opinion of Professor Kelly, CB-265. This risk was also noted by Dr Wood, who had telephoned the night registrar in charge on the evening of 28 May 2021 after learning that Mitchell was back in the hospital, in order to suggest that a repeat ECAT assessment occur. It is unclear how this and if this information was considered by the treating team.
[90] Opinion of the Chief Psychiatrist, CB-226.

assessment order.[91] She emphasised, and I accept, that Mitchell's medical and mental health issues were inextricably intertwined, insofar as "*there's the acute suicidality and the taking of the insulin and then the ongoing effects of the insulin, and I can't separate those as being two different events*",[92] and that accordingly, Mitchell's episodes of care needed to be viewed holistically whereby the physical effects of the suicide attempt were not yet resolved and treatment refusal was or may have been linked to the initial suicidality.

124. The Chief Psychiatrist agreed that an assessment order would have been indicated, emphasising that "*the evidence of mental illness is the high lethality attempt that he took in obviously very acute distress very recently that's still not resolved*"[93] and opining that an assessment order would have allowed time for further assessment of Mitchell. She emphasised "*that's what the assessment order is for. So the assessment order allows any ED or doctor that fills it in to hold the person for up to 24 hours so that you can get them to a psychiatric assessment*".[94]

125. Both the Chief Psychiatrist and Professor Kelly would have made an assessment order in these circumstances. Once an assessment order was in place, the clinicians could have called a Code Grey which would have prevented Mitchell walking out the door.[95]

126. However, both the Chief Psychiatrist and Professor Kelly accepted that different clinicians may have different views about whether it was reasonable to make an assessment order in these circumstances.

127. In hindsight, and as noted above, Dr Staples indicated that he would have taken further steps on the evening of 28 May 2021, including to assess Mitchell in person, which I note may indeed have added a layer of comfort for Dr Tile in providing care to a very complex patient. Dr Staples also indicates he would have taken further steps to escalate his concerns, including to escalate his concerns directly to ECAT or to the psychiatric registrar or consultant, or to override the ECAT assessment and place Mitchell on an assessment order

[91] Evidence at inquest of Professor Kelly, T-395 lines 2–14.
[92] Evidence at inquest of Professor Kelly, T-391 lines 15–18.
[93] Evidence at inquest of A/Prof Adams, T-409 lines 28–30.
[94] Evidence at inquest of A/Prof Adams, T-396 lines 9–12.
[95] Evidence at inquest of A/Prof Adams, T-437 lines 4–15.

himself. He noted that this was not his standard practice at that time, as it was usual to rely on the expertise and experience of ECAT clinicians in making such assessments.[96]

128. I consider that the frailties in Bendigo Health's systems of referral, escalation and information-sharing in place as of 28 May 2021 led to a failure in Mitchell being assessed under the Mental Health Act. Regardless of whether it would have changed the outcome for Mitchell, or would have resulted in an order being made, which cannot now be known with any certitude, this was a serious systems failure on the part of Bendigo Health in its care of Mitchell. It has revealed some opportunities for systems improvement that I will refer to further below.

Other aspects of care of Mitchell by Bendigo Health on the evening of 28 May 2021

129. I note for completeness that the evidence points to Dr Tile providing considered and competent care to Mitchell. In analysing other aspects of the care provided to Mitchell on the evening of 28 May 2021, Professor Kelly opined that: (i) it was reasonable for Dr Tile to consult with Dr Staples, the ED consultant, in relation to her concerns about Mitchell's presentation; (ii) the assessment that Mitchell had capacity (as opposed to whether he met criteria under the Mental Health Act) was appropriate; (iii) Dr Tile's explanation of risks of Mitchell leaving the ED was appropriate; and (iv) it was reasonable and appropriate to contact Mitchell's father in the circumstances upon Mitchell's self-discharge, with three attempts and a voice message being reasonable.

130. While I accept Professor Kelly's opinion on each of these factors, I note that Mitchell's father was contacted very late at night and that it is not surprising that contact was unable to be established, given the hour. Eddie believed at this point, once he had gone to bed, that Mitchell remained in the care of Bendigo Health, and needed to remain there.[97]

131. I consider that the timing of Mitchell's self-discharge ought to have (and clearly did) raise alarm bells for clinicians that Mitchell was leaving the hospital's care very late at night to

[96] Evidence at inquest of Dr Staples, T-223 line 31 to T-224 line 10.
[97] Eddie explained at inquest that he believed Mitchell was and should have remained in hospital after re-presenting there on 28 May 2021, "*because his blood sugars weren't going to be fixed in five minutes. It was quite obvious. He didn't make it very far when he left and then passed out. You don't have to be a doctor or a medical expert to work that one out. It's straightforward*". *See* T-44 lines 1–6.

home alone after a high-lethality suicide attempt with an ongoing risk of hypoglycaemia, where his father could not be successfully contacted, and where the known risk of him discharging was that he might die. While it was submitted to me carefully at inquest that this known risk of death was amplified by clinicians to Mitchell in an attempt to get him to stay in the care of the hospital, it was a risk that was known, and that indeed eventuated.

132. For despite leaving the hospital to go home alone where there was a significant quantity of additional insulin for Mitchell to take had he wished to, and which paramedics had initially raised concerns about, the evidence before me is that Mitchell died some hours after he self-discharged from hospital from the ongoing effects of his initial insulin overdose. It is trite to observe that, had he remained in hospital on the evening of 28 May 2021, whether of his own volition or under an assessment order, his death would likely have been prevented at that time.

133. It remains the case that, had Mitchell been assessed under the Mental Health Act, the clinician conducting that assessment may have found he did not meet the criteria for involuntary assessment and treatment, and that sadly, the tragic outcome may not have been avoided.[98]

134. However, given the omission of this critical step, and in light of the prevention function of this jurisdiction, any potential for improvement in Bendigo Health's systems should be identified, considered and vigorously pursued.

[98] This submission was made very strongly by Bendigo Health in closing submissions. In particular, Bendigo Health rejected the conceptualisation of Mitchell's case by Professor Kelly that *'it could be argued that life-threatening hypoglycaemia was an ill effect of a mental illness (depression/acute suicidality), that he was at serious risk of deterioration in his physical health (including death) and that he was not accepting of less restrictive treatment (voluntary treatment in hospital). In my opinion, this could justify the making of an Assessment Order under the* Mental Health Act*. This would have allowed Mitchell to be detained and treated without consent until a formal assessment by a psychiatrist' - see* Expert Opinion of Professor Kelly, CB-262-3. I consider Bendigo Health's concern to have been somewhat curious – I do not consider Professor Kelly to have impermissibly conflated two concepts in her characterisation of Mitchell's presentation. It was her evidence at inquest that Mitchell had a high lethality overdose with suicidal intent that had lingering effects – '*an absolutely full-on suicide attempt taken in a situation of crisis and that that was unresolved*' (T-413 lines 2-4) – and that the medical and mental health aspects of his care were therefore inextricably intertwined. I accept this categorisation and consider it militated towards clinicians assessing Mitchell's care holistically, including in relation to whether the Mental Health Act requirements were met in the context of his self-discharge where ongoing medical treatment and monitoring was required to address the ongoing effects of his initial intentional overdose. However, as the Mental Health Act assessment did not occur, and there is acknowledged variation in opinion as to making an AO in this context, I consider it unnecessary to address the issue further.

OPPORTUNITIES FOR SYSTEMS IMPROVEMENTS

135. Counsel Assisting impressed upon me in closing submissions—and, very appropriately, throughout her careful questioning of witnesses—that Mitchell's case was a very difficult situation with a complex interplay between mental health and physical health. A further complexity was that the circumstances occurred during the COVID-19 pandemic and a lockdown.[99] Clinicians working in hospitals during this period were doing so in what were often extreme and challenging circumstances, and this cannot be ignored.

136. It is also important to emphasise at the outset that the clinicians that I heard from at inquest who cared for Mitchell on 27 and 28 May 2021 demonstrated a high level of competence, empathy, care and self-reflection. I have not made any adverse comments about them in their role as individual clinicians caring for Mitchell. They provided thoughtful and considered evidence about what they did and did not know at the time of Mitchell's episodes of care, of how they work together across various teams both in May 2021 and subsequently, of the options they considered were available under the Mental Health Act as it then applied, and of their genuine care and concern of what might happen when Mitchell left their care while he remained at real risk of hypoglycaemia-related death without appropriate treatment and monitoring. Dr Tile in particular, who was a relatively junior doctor at the time of Mitchell's episode of care, expressed clear concern for Mitchell and has subsequently reflected at length and with great care in relation to these events.

137. However, hindsight has revealed opportunities for a series of systems improvements. In my view, Mitchell's two episodes of care have demonstrated the fragility of certain Bendigo Health systems as an organisation that led Mitchell to effectively "*fall between the cracks*" even where the risks associated with his refusal of medical treatment were wholly predictable and known to his clinicians. I am concerned that certain of these cracks—which were identified as early as the time of the RCA in 2021, but where Bendigo Health elected not to adopt the RCA's recommendations—may remain to this day in the absence of further organisational change occurring, and which I now turn to.

[99] This was a particular concern of Eddie's who wished to remain by Mitchell's side as much as possible within the restrictions that were then imposed at Bendigo Hospital for public health and safety reasons.

I. Clearer guidance, education and escalation pathways where someone is refusing medical treatment and is at risk of serious harm or death

138. Following consideration of the evidence of individual clinicians at inquest, and the evidence of Professor Kelly and A/Prof Adams, Counsel Assisting urged me to consider recommending that Bendigo Health implement a clear local policy or guidance to clinicians on what to do when a person is refusing treatment, where there is a risk of serious harm or death. This could include clarity on:

    a) Who can make an assessment order under the *Mental Health and Wellbeing Act 2022* (Vic) (**MHWA**), as is now in force;

    b) A trigger for when a person's mental state should be re-assessed; and

    c) Who to escalate concerns to where there remain concerns about a patient's mental state.

Who can make an assessment order?

139. It is clear from the evidence at this inquest that the issue of whether an assessment order is appropriate is a matter of clinical judgment, and reasonable minds may differ on whether, in the specific circumstances, the criteria under the MHWA are met. However, ED clinicians should be reminded that they have the power to make an assessment order where the criteria are met, with steps taken to increase their confidence in making assessment orders where indicated.[100]

140. Professor Kelly, who practised emergency medicine for many years when there were no mental health workers in EDs, and who stated that she is very comfortable using mental health legislation, opined that this confidence could be uplifted through education, and by case studies and by conversations.[101] I consider this to be an appropriate means to address the at-times reticence of ED clinicians to undertake such assessments when there are specialist mental health clinicians on staff.

[100] Evidence at inquest of A/Prof Adams, T-399, lines 29–30.
[101] Evidence at inquest of Professor Kelly, T-399 lines 7–25.

141. Dr Mathias' evidence at inquest demonstrated the appropriately high stakes of such decision-making; he noted that "*subjecting someone to the Mental Health Act and essentially treating them against their autonomy is a big decision to make, so it's not something that I would necessarily take lightly*".[102]

142. However, Dr Mathias and other clinicians also appeared to advocate for a two-step approach that preserved the role of ECAT in making any ultimate assessment under mental health legislation, namely that "*the formal mental health assessments are done by our ECAT team however there's nothing stopping us as clinicians from doing that as well but the initial review would just be … a triage to say do they need, do we need to bring in mental health again*".[103] Conversely, Dr Staples indicated that following Mitchell's case, his confidence in using mental health legislation himself would now be higher.[104]

143. Without opining on which approach is optimal in any given circumstances, as Mitchell's case demonstrates, further reminders for ED clinicians on applying mental health legislation where the relevant criteria are made out would be of great utility.

When should a person's mental state be re-assessed?

144. The RCA findings included that "*there was no system trigger to ensure an automatic face to face review by ECAT when Mitchell re-presented within a short timeframe of his previous ED admission and review*".[105] Indeed, the evidence at inquest supports that there was, and remains, no clear guidance on the triggers on the need for a re-assessment of mental health or the need to consider whether the Mental Health Act applied.[106]

145. Dr Mathias' evidence was that "*it's pretty standard practice … if a patient were to change either in their physical or psychiatric or mental health state that we would reassess the patient at that point in time…So you know an initial assessment is not a static assessment that occurs over the entire course of their both presentation to the Emergency Department*

[102] Evidence at inquest of Dr Mathias, T-76 lines 10–15.
[103] Evidence at inquest of Dr Mathias, T-66 line 31 to T-67 line 7.
[104] Evidence at inquest of Dr Staples, T-231, lines 17–26.
[105] As reflected in the statement of Dr Ferres, CB-44.
[106] *See for example* the evidence at inquest of Ms Trickey, T-115 lines 17–20.

and admission to hospital, it is something that is dynamic and always changes so I think that's an inherent understanding I would imagine".[107]

146. However, and while noting it is not possible or desirable to be too prescriptive, the Chief Psychiatrist's opinion was that local policies and procedures ought to articulate that a patient's mental state should be re-assessed at any significant change in their presentation, as well as addressing all relevant escalation pathways, to which Professor Kelly agreed. Professor Kelly also noted that it would also be helpful "*to have some examples in the policy and procedure about what some of those triggers might be. So somebody declining - withdrawing their consent to treatment or wanting to leave against - against advice or just to give some examples to at least give a frame of things*".[108]

Who should concerns about a patient's mental state be escalated to?

147. The RCA findings included that "*there was a lack of an agreed, formal escalation plan for ED staff to use for mental health concerns – such as those used for physical escalation of care (MET call), leading to events such as ED staff not notifying ECAT when the patient was discharging himself against advice despite their concerns, resulting in ED staff feeling unable to escalate their concerns and the patient being able to self-discharge*".[109]

148. The 'Clinical Review Escalation Protocol' in force at the time of Mitchell's episode of care is in evidence in these proceedings.[110] However, it did not include a clear formal escalation plan for ED staff to use where they had mental health concerns in relation to a patient in their care.

149. The current 'Clinical Escalation Procedure' now includes a flowchart entitled '*Recognising and responding to acute mental health deterioration*' (**Flowchart**).[111] However, the Escalation Pathways do not make it clear that either ED clinicians or the ECAT can escalate

[107] Evidence at inquest of Dr Mathias, T-65 lines 14–22.
[108] Evidence at inquest of A/Prof Adams, T-422 lines 4–24; Professor Kelly, T-423 lines 12–18.
[109] As reflected in the statement of Dr Ferres, CB-44.
[110] At CB-95.
[111] At CB-141 (see Appendix 4 at CB-158).

to the psychiatrist on call, which Counsel Assisting submitted is a gap that should be filled,[112] and which I accept.[113]

What opportunities are there for further education?

150. Counsel Assisting also submitted that ED clinicians would benefit from education or information from the Office of the Chief Psychiatrist (**OCP**) in relation to:

    a) Assessment Orders—in particular,

        i. what they can be used for;

        ii. the thresholds for when an assessment order can be made; and

        iii. immunity for clinicians acting in good faith.

    b) Importantly, any such guidance should provide:

        i. clarity on the 'grey space' of what treatment can be given to a patient subject to an assessment order;[114] and

        ii. whether and when a patient subject to mental health legislation can be used to treat physical health issues—in this case, Mitchell's blood sugar levels.

151. The Chief Psychiatrist, A/Prof Adams, considered that provision of specific guidance can be potentially problematic because of the broad range of situations that clinicians might face. A/Prof Adams emphasised that for this reason, the OCP has created a "*principles*

[112] *See* evidence of A/Prof Tune at T-246 *et seq*. about escalation options in Mitchell's case and how the escalation policies assist clinicians, whereby he noted that the ED registrar appropriately escalated her concerns to the ED consultant, whose options were then to gather more information and then seek further advice from the ECAT clinician and if not satisfied with the advice, to escalate his concerns to the psychiatric registrar or consultant psychiatrist. This sits in tension with the evidence of the ED consultant Dr Staples who stated that he could not confirm or refute whether the consultant psychiatrist was an available escalation process as he had never before been required to do so. *See* T-235 lines 22–27. A/Prof Adams confirmed that it would have been useful to have a policy stating that the ED staff could have escalated to the psychiatrist on call. *See* T-424 lines 7–11.

[113] I note that initial steps have been taken to supplement the current Flowchart with additional bullet points to clarify points of escalation (*see* AM-1) though this was not formal Bendigo Health policy at the time of inquest.

[114] There was some evidence about this at inquest insofar as a patient on an assessment order might be treated with the basics to keep them alive but not "*higher order medical treatments*" such as heart surgery or amputation. *See*T-377 lines 19–28.

paper for risk assessment rather than a 'how to'".[115] This principles paper is the OCP's 'White paper: On the principles of mental health risk assessment' (**White Paper**).[116]

152. I consider this to be a very useful contemporary tool in terms of the guidance it can provide clinicians assessing risk in complex circumstances. It obviously came into existence after Mitchell's episodes of care and was not available for the consideration of clinicians involved with him at the time. However, the information on risk assessment in the White Paper makes for critical reading for ED and mental health clinicians alike. I previously considered the White Paper where similar complex decision-making on risk factors was required to be conducted, noting that "*I am hopeful that the White Paper issued by the Office of the Chief Psychiatrist…may provide clinicians with a useful set of principles to assist in broaching the multi-faceted dimensions of risk formulation to make highly complex decisions in relation to members of our community who are often the most vulnerable*".[117]

153. In addition to the more general role played by the White Paper, A/Prof Adams also considered there much work to be done in implementing the *Mental Health and Wellbeing Act 2022* in EDs.[118] A/Prof Adams noted that the OCP was undertaking ongoing work with EDs and referred with approval to the Black Dog Institute recommendations[119] which include "*a whole lot of suggestions for how EDs and mental health can work together which would actually help this culture of shared decision making*".[120]

154. I therefore consider, as ultimately urged upon me by Counsel Assisting, that it ought to be a matter for the Chief Psychiatrist to determine what further appropriate form of education might flow from the circumstances underpinning Mitchell's episodes of care, in the context of its existing work in promoting the appropriate use of mental health legislation in EDs, including (a) highlighting Mitchell's case as a case study, including the challenges of the

[115] Evidence at inquest of A/Prof Adams, T-438 line 28 to T-349 line 6.
[116] Available here, published in October 2024. A copy was also tendered during inquest and forms part of the coronial brief at AM-6.
[117] Finding into the death without inquest of Ms YPM, COR 2020 2609, 16 October 2025, para 348, available here.
[118] Evidence at inquest of A/Prof Adams, T-439 line 7 to T-440 line 22.
[119] 'Recommendations for integrated suicide-related crisis and follow-up care in emergency departments and other acute settings', Black Dog Institute, published November 2017 and revised August 2023. *See* AM-5.
[120] Evidence at inquest of A/Prof Adams, T-440 lines 12–17.

interaction between the ongoing medical impact of the suicide attempt and attendant mental health considerations; and (b) if appropriate, discussing the confident use of assessment orders (where indicated) to give clinicians time to de-escalate and assess the situation, have time to assess a patient and determine the optimal path forward.[121]

155. Counsel Assisting submitted, and I accept, that statewide guidance or information of this ilk would be the most effective way of realising Eddie's concern to harness all available systemic improvements and to ensure that Mitchell's circumstances are not repeated, rather than guidance being provided to Bendigo Health alone. In this regard, I consider that Safer Care Victoria also has a role, and an apposite recommendation will be made.

II. Better integration of medical and mental health treatment planning

156. Following consideration of the evidence of individual clinicians at inquest, and the evidence of Professor Kelly and A/Prof Adams, Counsel Assisting also urged me to consider recommending that Bendigo Health take steps to facilitate better integration between the ED and the ECAT in relation to a patient's treatment planning, including any required clarification of the ECAT referral process.

157. The RCA findings included that "*manual duplication of the immediate mental health plan in community psychiatry digital medical record (**CPDMR**) across to the Electronic Patient Record (**ePR**) which contributed to the ePR plan missing key information regarding Mitchell's level of risk and decision making. This resulted in ED staff not knowing the full extent of the immediate plan that included a necessary protective factor (going home in the care of his father)*".[122]

158. The RCA also found that "*a lack of integration of the Immediate Mental Health Plan and physical plan of care, leading to the plans being delivered in isolation, resulting in key*

[121] Compellingly, A/Prof Adams gave evidence at inquest that "*So when in doubt I'd like ED doctors to use AOs and then they can see a psychiatrist who might very happily take them off, but the situation has de-escalated, you've had time to have a safety plan, you've got a family member in. That's a much safer way to go home*". – *See* T-409 lines 1–5, though she also carefully acknowledged that any consideration of an assessment order always involves a balancing act and the consideration of consumers' human rights, and that it is difficult to reduce the process of risk assessment to concrete guidance, given the balancing of multiple considerations in unique situations – *see* T-461.
[122] As reflected in the statement of Dr Ferres, CB-44.

issues – such as the severity of Mitchell's physical condition and likelihood of self discharge – then not being incorporated into decision making".

159. Ms Trickey was not aware of any guidance or policy from Bendigo Health that there be discussion between the ED and the ECAT in relation to Mitchell's medical and mental health risks.[123] Dr Mathias' evidence was that ED clinicians and ECAT clinicians "*typically have a very good collegiate relationship that allows us to have a back-and-forth relationship*" where ED clinicians are advised of the ECAT plan.[124]

160. However, the evidence in this case is that there were only two discussions between the ECAT and the ED:

    a) First, Ms Trickey would have reported to the Nurse Unit Manager that she had seen Mitchell on the evening of 27 May 2021; and

    b) Second, there was a discussion between 9.30pm and 10.00pm on 28 May 2021, the contents of which are disputed, following Mitchell's re-presentation to the ED earlier that evening.

161. Counsel Assisting submitted, and I accept, that there is no evidence in the medical records of face-to-face discussion of Mitchell's medical or mental health risks, or how these factored into treatment planning. An apposite recommendation will be made.

Record-keeping systems

162. The evidence of Associate Professor Philip Tune (**A/Prof Tune**) and Dr Yvonne Higgott (**Dr Higgott**) at inquest was that there have been changes and improvements in how information is shared between the ED and the ECAT since Mitchell's episodes of care; and the evidence of Dr Mathias is that he believed most ED clinicians now have access to the ECAT documentation system if they wanted to see a more detailed assessment beyond the 'cut-and-paste' of what the ECAT has placed in the medical file.[125]

[123] Evidence at inquest of Ms Trickey, T-116 lines 1–2.
[124] Evidence at inquest of Dr Mathias, T-60 lines 24–29.
[125] Evidence at inquest of Dr Mathias, T-63 lines 25–28.

163. The evidence of the Chief Psychiatrist was that ideally there should be one single electronic management record system that ED and mental health clinicians should use.[126]

164. The status of the information-sharing at Bendigo Health between the ED and the ECAT was not clear and appears to be the subject of ongoing work (including as to the commissioning of a 'two-way link' between the CPDMR and ePR that would allow clinicians to toggle between the two systems to apprise themselves of a patient's medical and mental health issues respectively, across the two systems).[127] However, the timeframe for implementation of this was unknown as of the time of inquest.

165. In the absence of a single electronic record advocated by the Chief Psychiatrist, information-sharing via access to relevant record-keeping systems (in addition to face-to-face discussions) should be an ongoing focus for Bendigo Health to ensure that there is consistency of practice with what information is shared, and that all necessary information is accessible.[128]

Integrated planning of medical and mental health treatment

166. Professor Kelly provided an opinion that, in a case such as Mitchell's, interdisciplinary discussion between a treating senior ED doctor and the ED mental health worker should occur after the initial mental health assessment to discuss the medical and mental health risks, following which an integrated plan should be developed to address and document:

    i. physical risks and treatment;

    ii. mental health risks and treatment/follow up; and

[126] Evidence at inquest of A/Prof Adams, T-416 lines 28–29.
[127] Evidence at inquest of A/Prof Tune, T-261 line 29 to T-263 line 29.
[128] Professor Kelly's evidence at inquest was also on point here: "*So I don't think it's just enough to do a copy and paste, and especially if they copy and paste the whole narrative where the important information is the second line from the bottom of the third page, scroll down. You'll never find it. So I think there needs to be an efficient way of sharing written information but also that doesn't replace the clinician to clinician conversation to be clear about combined risk when there is a potential physical issue*". *See* T-419 lines 17–25.

iii. what should happen if risks in either domain change (e.g. a plan if the patient tried to self-discharge while medical risk remained high).[129]

167. Professor Kelly also opined that given Mitchell's pattern of discharging against medical advice, the integrated management plan should have included a plan if he tried to self-discharge while the medical risk remained high.

168. Dr Mathias saw the benefit of having integrated plans of the kind described by Professor Kelly in her report but considered that is what currently exists and that such integration "*seems to be inherent in what we do in our day-to-day approach to treating patients*".[130]

169. While that may be the case in the majority of cases, given the circumstances of Mitchell's case, and in light of the expert evidence, I am of the view that consideration should be given:

a) to including in the local policy that the default is that there are documented interdisciplinary consultations between ED clinicians and ED mental health workers before and/or after the initial mental health assessment to discuss the medical and mental health risks; and

b) to developing steps to ensure there is an integrated management plan, that incorporates medical and mental health risks.

170. This would assist in addressing a further finding of the RCA that "*there was a difference in the understanding between ECAT and ED of the broad terminology 'cleared' leading to ED staff believing patients who are 'cleared' by ECAT have no mental health risks or conditions/criteria for their discharge, resulting in ED staff focussing solely on the physical risk and the patient then being able to self discharge*".

171. The Chief Psychiatrist A/Prof Adams' evidence was that the word 'cleared' in a mental health context was "*really unhelpful*" insofar as you cannot be 'cleared' for something that

[129] Expert opinion of Professor Kelly, CB-269.
[130] Evidence at inquest of Dr Mathias, T-80 lines 6–16.

is "*dynamic*".[131] Including interdisciplinary discussions in local policy, as referred to above, would mean that such shorthand would not be relied upon and would instead be enhanced by more nuanced discussions.

Better defining what constitutes a referral to ECAT

172. The practice at the time of Mitchell's episode of care, and currently, is that referrals to the ECAT are made by phone call or face-to-face. The RCA found that in this case, this led to:

    a) the referral processing being 'informal'; and

    b) miscommunication occurring regarding the intent of the discussions.

173. However, Bendigo Health reviewed its practice, and following that review, it was considered the existing ED-ECAT referral process works well for both teams.

174. While the implementation of an ECAT dashboard has provided a further means by which to formalise records of referrals made to the ECAT, Professor Kelly opines, and I accept, that Bendigo Health should better define what constitutes a referral and consider adding "*referred to mental health*" on its ED patient management/record system.[132] I accept the premise of the recommendation, noting that there was some disparity at inquest between what was considered a 'formal' and 'informal' ECAT referral, and that this issue represented a key rupture point in Mitchell's care on the evening of 28 May 2021.[133]

III. Written instructions for family/carers at the point of discharge

175. Finally, Mitchell's father Eddie was a key protective factor and a key pillar in his discharge planning. The ECAT plan was:

[131] Evidence at inquest of A/Prof Adams, T-421, lines 3–5.
[132] Expert opinion of Professor Kelly, CB-269. In terms of updates to systems since the time of Mitchell's episode of care, such as the ECAT dashboard, I note that A/Prof Tune was not aware of whether a snapshot of the dashboard appears in the patient file and Dr Higgott noted the dashboard was not specific to mental health, but applies to all patients in the ED. Therefore, unless there is additional functionality to the dashboard that was not revealed at inquest, I consider Professor Kelly's recommendation to remain apposite.
[133] Curiously, Bendigo Health appeared to maintain that the conversation between Ms Trickey and Dr Tile was evidence of an integrated meeting regarding Mitchell's care, notwithstanding the very different understandings both clinicians had of that conversation (*see* T-528 lines 26-27). I do not accept the submission, which appears to conflate the concepts of a multidisciplinary discussion with a genuinely integrated mental health and medical plan.

a) for medical clearance re diabetes and OD [overdose]; and

b) D/C [discharge] home with father.

176. One learning following the RCA was that "*when the ECAT plan was for Mitchell to be discharged (when physically cleared) into the care of a nominated person (father) as a protective factor, Mitchell's father was not provided with a written copy of this with follow up details, the need to report behaviour changes, crisis service numbers and the need to remove any potentially lethal means of self-harm (insulin)*". There was no requirement in Bendigo Health policies that there be written instructions provided to Mitchell's father as his carer.[134] The expert evidence supports that where a patient is assessed by a mental health clinician as being able to be discharged from the ED into the care of a person, written instructions should be provided to that person on:

a) the need to report behaviour changes;

b) crisis service numbers; and

c) the need to remove any potentially lethal means to self-harm, which was pertinent to Mitchell as he was being discharged back home with multiple boxes of insulin.

177. This requirement does not appear to be made clear in a local policy. I accept the submissions of Counsel Assisting that it should be.

FINDINGS

178. Pursuant to section 67(1) of the Act, I make the following findings:

a) the identity of the deceased was Mitchell Dean Johns, born 28 May 1993;

b) the death occurred on 29 May 2021 at 1/26 Curtin Street, Flora Hill, Victoria, 3550, from *hypoglycaemia due to administration of exogenous insulin*; and

c) the death occurred in the circumstances described above at paras [30]-[76].

[134] Evidence at inquest of Ms Trickey, T-109 lines 2–4.

179. I find that Mitchell's tragic death occurred following his decision to procure and ingest large quantities of rapid and long-acting insulin with the intention of taking his own life, in the context of longstanding mental and physical ill health, suicidality, and a recent relationship breakdown.

180. I find that the response and treatment provided to Mitchell by the first responders who attended to him and transported him to Bendigo Hospital on the afternoon of 27 May 2021 and evening of 28 May 2021, was appropriate and demonstrated a high level of competence and care.

181. I find that Mitchell was appropriately assessed as having functional capacity to make the decision to self-discharge against medical advice from Bendigo Hospital on the two occasions that he did so, firstly on the afternoon of 28 May 2021 (**first self-discharge**) and secondly on the evening of 28 May 2021 (**second self-discharge**).

182. I find that Mitchell also underwent an assessment under the *Mental Health Act 2014* at the point of his first self-discharge by an experienced doctor who determined, based on information available to them, that he did not then meet the criteria for an assessment order.

183. However, in relation to his second self-discharge, despite the concerns of a doctor in the emergency department about Mitchell's mental state, and despite that this doctor appropriately contacted the Enhanced Crisis Assessment Team (**ECAT**) on the evening of 28 May 2021 in relation to Mitchell, I find that no formal assessment of Mitchell under the *Mental Health Act 2014* was ultimately conducted before he left the hospital for a second time. This was a serious failure on the part of Bendigo Health. Consideration of an assessment order should have occurred because of Mitchell's refusal of medical treatment, his re-admission with a further episode of life-threatening hypoglycaemia and the real risk of mortality if he self-discharged.

184. While it cannot now be known what the outcome of an assessment would have been under the *Mental Health Act 2014* on the evening of 28 May 2021, the weight of the expert evidence supports that a mental health assessment ought to have occurred and did not. Had an assessment order been made, Mitchell could have been detained and treated for his

insulin overdose until a formal assessment by a psychiatrist occurred, rather than leaving the hospital to go home alone, where tragically, he was found deceased some hours later.

185. In these circumstances, I accept the expert opinion of Professor Kelly and find that Mitchell's death was potentially preventable.

186. In so finding, I make no adverse comment about the individual clinicians involved in Mitchell's care, who all acted in what they believed to be Mitchell's best interests based on the information known to them at the relevant time. Indeed, I was struck by the deep care and reflection of many of the clinicians involved in Mitchell's treatment, all of whom were providing care in very challenging and complex circumstances.

187. However, I find that the systems in place at Bendigo Health at the time of Mitchell's episodes of care did not support integrated and informed decision-making by the mental health and medical teams, with staff from both disciplines lacking key information known to the other that may have critically impacted their perception and assessment of Mitchell's level of risk. This led to a situation in which, despite the known and predictable risk that Mitchell could die from complications flowing from his initial suicide attempt—namely recurrent episodes of hypoglycaemia that required ongoing treatment—he self-discharged from the hospital on the night of 28 May 2021 without his mental health being formally re-assessed and without the knowledge of his key protective factor—his father.

188. I have taken some comfort from the evidence of Associate Professor Tune that if a similar circumstance were to arise today, a different outcome would be likely, including insofar as Emergency Department clinicians would likely be more confident in using relevant mental health legislation themselves, if required. There also appear to have been certain changes to information-sharing arrangements between the mental health and ED teams at Bendigo Health which will go some way towards improving patient care and safety.

189. I find, however, that further systems improvements are still required to best support the safety and wellbeing of those who present following a suicide attempt where there are concurrent medical and mental health considerations, and will make four apposite recommendations. Pertinent comments also arise.

COMMENTS

I make the following comment(s) connected with the death under section 67(3) of the Act:

1. Mitchell's episodes of care give rise to fundamental questions of law, medical ethics and human rights. These issues are deeply complex ones upon which reasonable minds might differ, including those of clinicians, carers, and people with lived experience of mental ill health. The tragic outcome of Mitchell's case also underscores the importance of having clear local policies and education for ED and mental health clinicians alike on processes for referral, escalation, communication and integrated care planning.

2. While Mitchell's episodes of care occurred during the operation of the former *Mental Health Act 2014*, the inquest also raised important questions about mental health and wellbeing principles that are now formally enshrined in the new *Mental Health and Wellbeing Act 2022*. Such principles include the '*dignity of risk*', '*dignity and autonomy'*, and providing treatment and care to a patient or consumer via the '*least restrictive'* means.

3. At inquest, the Chief Psychiatrist helpfully explained that the principle of the '*dignity of risk*', in a mental health context:

> *…emphasises the importance of people making their own life choices, and being supported to do so, even when those choices don't align with what other people might think. It's because we believe that people being able to make their own choices aligns with their opportunity to live a flourishing life, and to have their best chance often in a longer-term psycho-therapeutic interaction of actually becoming well. […] We do believe people have the right to take reasonable risks, but the word that's probably relevant is 'reasonable' and the dignity of risk doesn't extend to being able to choose impulsively to do something, but it does extend if there's an authentic long term life choice that we would potentially support intentionally, but with thorough assessment and decision making over a period of time.*[135]

[135] Evidence of Chief Psychiatrist, T-378 lines 4-26.

4. From an emergency medicine perspective, Professor Kelly underscored that the principle of the dignity of risk '*is not something that is usually front of mind in an emergency department where we're dealing with crisis situation. Emergency physicians are aware of it as a principle of the Act and a principle of patient care in general, but it is not something that usually is front mind in a crisis situation*'. Both Professor Kelly and the Chief Psychiatrist emphasised that following an acute suicide attempt where the risk of death is imminent if treatment is not provided, '*that would just tip the balance away from the dignity of risk and towards treatment and then re-institution of the dignity of risk after that treatment*'.[136]

5. It is a salient reminder that, while potentially overlapping, the assessment of a patient's functional decision-making capacity involves distinct issues of principle and law to those enshrined in the *Mental Health and Wellbeing Act 2022*, such as the '*dignity of risk*'.

6. I consider the inquest provided useful reflections as to how issues of risk, human rights and patient autonomy might be balanced in an emergency department context, including as to how care is delivered to patients who seek to act outside their own best interests, and the potential implications for their assessment and providing treatment in the short-term.

7. For while the current Act is often conceived of as a shift away from clinician-led care towards supported decision-making, autonomy, dignity of risk, and least restrictive care, which rightly reflects the presumption that individuals are capable of making their own decisions and that their views and preferences should be prioritised wherever possible, it can also create a tension. This tension arguably existed under the former 2014 Act, particularly where a person – like Mitchell – has attempted suicide by a method such as a long-acting insulin overdose and, at the time they seek to discharge, appears to be calm and cooperative, retains decision-making capacity, and might conceivably be assessed by some clinicians as not meeting the criteria for compulsory assessment or treatment, yet remains at substantial risk of death from the physiological consequences of the overdose for many hours or days.

[136] Evidence of Professor Kelly, T-380 lines 7-12 and T-280 lines 12-15.

8. In these circumstances, the clinical risk is not necessarily driven solely by the person's current mental state. Rather, it stems from the enduring medical consequences of an earlier decision to attempt suicide. It is a grey area that sits at the intersection of medicine, mental health, autonomy and patient safety, and one for which there does not appear to be an easy solution. However, a holistic view of care and treatment for such patients is arguably critical, as is clear communication between treating teams, along with genuine integration of medical and mental health care planning. Sharing written information is important, but does not replace the clinician-to-clinician conversation to be clear about combined risk.

9. In the era of the new *Mental Health and Wellbeing Act 2022*, and while noting this is not the only cohort requiring training and information on risk assessment, targeted education for Emergency Department clinicians may be helpful in navigating these complex but important principles in time-critical situations. While noting that there is excellent recently-published information on interpreting principles in the new Act for mental health and wellbeing service providers,[137] there remains a clear role for emergency medicine-specific information and education to ensure that our ED clinicians are also well-supported and confident to make decisions under the Act, where required.

RECOMMENDATIONS

I make the following recommendations connected with the death under section 72(2) of the Act:

a) I recommend that **Bendigo Health** revise its local policies and procedures to ensure that, where a patient has attempted suicide and is refusing medical treatment and is at risk of serious harm or death: (i) there is clear guidance on who can assess the patient and, if indicated, make an assessment order under the *Mental Health and Wellbeing Act 2022* (Vic); (ii) there is a systems trigger for when a person's mental state should be assessed and re-assessed; and (iii) there is clear guidance on who to escalate concerns to about a patient's mental state.

[137] *See* 'Mental health and wellbeing principles guidance - From intent to impact', Mental Health and Wellbeing Commission, December 2025, available here. The OCP's White Paper is also deeply relevant in this regard.

b) I recommend that **Bendigo Health** develop clear requirements to ensure, for patients who have attempted suicide, that there is integration of medical and mental health planning in the Emergency Department (**ED**), including requiring a documented consultation between a treating senior ED doctor and the ED mental health clinician after an initial mental health assessment to discuss any medical and mental health risks, following which an integrated plan should be developed to address and document: (i) physical health risks and treatment; (ii) mental health risks and treatment/follow up; and (iii) what should happen if risks in either domain change.

c) I recommend that **Bendigo Health** develop a process to ensure that when a patient has attempted suicide and is discharged from the ED into the care of another person, written instructions should be provided to that person on: (i) monitoring and reporting changes in the patient's behaviour; (ii) available crisis support services and emergency contact numbers; and (iii) removing or restricting the patient's access to potentially lethal means of self-harm.

d) I recommend the **Office of the Chief Psychiatrist** in consultation with **Safer Care Victoria,** and those with lived experience of mental ill health, develop and disseminate statewide education for emergency departments on managing patients who present following a suicide attempt where there are concurrent medical and mental health considerations, having regard to the issues identified in Mitchell's episodes of care.

ACKNOWLEDGMENTS

I convey my sincerest sympathy to Mitchell's family and friends for their tragic loss. In particular, I thank Eddie, Mitchell's father, for his active participation, care, assistance and attendance throughout these proceedings. I also acknowledge Mitchell was a member of the LGBTIQA+ community, for whom there are known rates of higher suicidality, mental ill health, and social exclusion, which is an important contextual factor to acknowledge in a finding of this nature.

I also thank in particular Counsel Assisting, Fiona Batten, for her exceptional assistance throughout the inquest, as well as the counsel and solicitors who represented the interested parties. I also acknowledge and thank the Court's Legal Services staff for the invaluable assistance and support provided throughout the inquest, along with the CPU for its key contribution to these

proceedings. Finally, I acknowledge Leading Senior Constable Declan Douglas, coronial investigator, for his assistance during the investigation.

ORDERS AND DIRECTIONS

Pursuant to section 73(1) of the Act, I order that a copy of this finding be published on the Coroners Court of Victoria website in accordance with the Rules.

I direct that a copy of this finding be provided to the following:

Mr Edward Johns, Senior Next of Kin
Bendigo Health c/o K&L Gates
Ms Leanne Trickey c/o Lander & Rogers
Dr Natasha Tile c/o HWL Ebsworth
Professor Anne-Maree Kelly, Emergency Physician
Chief Psychiatrist of Victoria
Ambulance Victoria
Australian College of Emergency Medicine
Royal Australian and New Zealand College of Psychiatrists
Safer Care Victoria
Financial Assistance Scheme (formerly VOCAT)
Leading Senior Constable Declan Douglas, Coronial Investigator

Signature:

INGRID GILES
CORONER

Date: 31 August 2026

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an inquest. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.